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HD 4673

H4279

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE • BOSTON 02133
(617) 725-4000

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

July 20, 2005

To the Honorable Senate and House of Representatives:

Today I am filing for your consideration "An Act to Increase the Availability and Affordability of Private Health Insurance to the Residents of the Commonwealth". In April, I filed two important pieces of the legislation to make affordable health insurance products more available for our small businesses and individuals by reforming the Commonwealth's small group and non-group insurance laws and creating a health insurance exchange. These bills will make health insurance products more affordable and available to over 200,000 of our uninsured residents.

This legislation incorporates those two bills and creates Safety Net Care, a new program to deliver premium assistance for the purchase of private health insurance products. Safety Net Care will assist the approximately 150,000 uninsured residents that do not qualify for Medicaid, but earn less than three times the federal poverty level and do not have access to employer subsidized health insurance. Today, we spend approximately $1 billion on the medical cost for the uninsured. Safety Net Care redirects this spending to achieve better health outcomes in a more cost-effective manner.

With Safety Net Care in place, it is fair to ask all residents to purchase health insurance or have the means to pay for their own care. This personal responsibility principle means that individuals should not expect society to pay for their medical costs if they forego affordable health insurance options. People who have not purchased health insurance, or cannot show they have the means to pay for their own care, face the penalty of losing their personal exemption on their state income tax return.

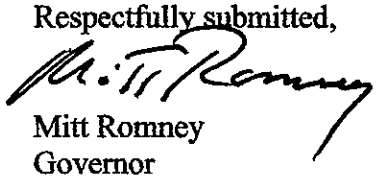
This legislation also includes plans to launch a consumer-friendly web site that will include comparative information on hospitals and providers. Quality and costs may vary by hospital or physician and it is confusing for consumers who do not have access to comparative measures. The "Patient Right-to-Know" website will help consumers better understand medical costs and quality measures through a single portal.

Finally, this legislation provides our municipalities with the same authority as the Commonwealth for the design and selection of health insurance products. Through the

establishment of a local group insurance commission, municipalities will be better able to manage their health care costs.

I urge your prompt and favorable consideration of this legislation.

Respectfully submitted,



Mitt Romney
Governor

House, No. 4279

BILL

1250 pm 7/28/05

HD4673

H. 4279

The Commonwealth of Massachusetts

IN THE YEAR TWO THOUSAND FIVE

AN ACT TO INCREASE THE AVAILABILTY AND AFFORDABILITY OF PRIVATE HEALTH INSURANCE TO RESIDENTS OF THE COMMONWEALTH

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 7 of the General Laws is hereby amended by inserting the following:-

Section 57. (a) There shall be within the executive office for administration and finance, but not subject to its control, a transition provider assistance board. The members of the board shall be the secretary for administration and finance, ex officio who shall serve as chair; the secretary of health and human services, ex officio; and the secretary of economic development, ex officio. Each member of the board serving ex officio may appoint a designee pursuant to section 6A of chapter 30.

(b) Three members of the board shall constitute a quorum, and the affirmative vote of 2 members of the board shall be necessary and sufficient for any action taken by the board. The purpose of the board shall be to allocate transitional assistance

funds to acute care hospitals, and community healthy centers for the provision of medically necessary care to uninsured residents of the commonwealth, based on the criteria described herein.

(1) To develop criteria to be used to distribute the funds in consultation with the division of health care finance and policy. The commissioner of the division of health care finance and policy shall make recommendations to the board for such criteria, which may include, but not be limited to, each provider's proportion of allowable care costs that are not paid for by the recipient, prior to implementation of the Safety Net Care Health Insurance program.

(2) To develop criteria to award hardship relief for qualified hospitals and community health centers, including but not limited to, demonstration of severe financial distress which jeopardizes the delivery of health care services, and demonstration that that provider delivers a disproportionately high level of care services that are not paid for by the recipient.

(3) To seek and receive any grant funding from the Federal government, departments or agencies of the commonwealth, and private foundations.

(4) To enter into contracts with other state agencies for service as may be necessary in its judgment to carry out its business.

(5) To contract with professional service firms as may be necessary in its judgment, and to fix their compensation.

(6) To do all things necessary to carry out the purposes of this chapter.

(c) The board shall require hospitals and community health centers to submit to the division of health care finance and policy such data it deems necessary.

(d) Acute hospitals or community health centers may file an application with the board to apply for state assistance under the provisions of this section; provided that the acute hospitals or community health center has demonstrated that they have used their best efforts to collect any unpaid debts. Upon receipt of the application, the board shall cause an investigation to be made, taking into consideration the criteria as described in subsection (b).

(e) The Board is authorized to requisition funds from the Safety Net Care Expendable Trust Fund for deposit into the Safety Net Transitional Assistance Trust Fund by notifying the secretary for administration and finance in a form prescribed by the secretary such amounts as the board deems necessary to allocate transition assistance funds to acute hospitals and community health centers.

(f) The board shall submit annual reports on the disbursements of transition funds to the Legislature.

(g) The secretary for administration and finance shall promulgate such rules and regulations as necessary to carry out the purposes of this section.

SECTION 2. Section 8H of chapter 26 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking in lines 49-50, the words "including hospital and other services funded through the uncompensated care pool, under section 18 of chapter 118G"

SECTION 3. Chapter 29 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by adding the following:-

Section 2*OOO*. There shall be established on the books of the commonwealth the Medical Escrow Account Fund, which shall be administered by the secretary for administration and finance, which shall consist of amounts withheld from tax payers pursuant to section 2 of chapter 111A. All interest earned on the amounts in said fund shall be deposited or retained by the fund on behalf of the individual taxpayers. Amounts credited to the fund shall be held as an expendable trust and shall not be subject to further appropriation.

Section 2PPP. (a) There shall be established on the books of the commonwealth the Safety Net Care Expendable Trust Fund, which shall be administered by the secretary for administration and finance, which shall consist of all amounts paid by hospitals and surcharge payors as defined in section 1 of chapter 176R, and all federal financial participation revenue on Safety Net Care payments made pursuant to chapter 176R; all property and securities acquired by and through the use of monies belonging to said fund and all interest thereon. All interest earned on the amounts in said fund shall

be deposited or retained by the fund. The monies allocated by the secretary to fund the Safety Net Care Health Insurance Program pursuant to 176R, as administered by the Commonwealth Care Health Insurance Exchange established in chapter 176Q, shall have priority over payments to the Safety Net Transitional Assistance Trust Fund; provided the comptroller shall transfer to the Safety Net Transitional Assistance Trust Fund at least $250 million in Fiscal Year 2007; $200 million in Fiscal Year 2008; and $100 million in Fiscal Year 2009. Amounts credited to the fund shall be held as an expendable trust and shall not be subject to further appropriation. No expenditure made from the fund shall cause the fund to be in deficit at the close of each fiscal year.

Section 2QQQ. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Medical Assistance Trust Fund, administered by the secretary of health and human services. There shall be credited to the fund: (a) any funds directed to the commonwealth from public entities and (b) federal reimbursements related to medical assistance payments funded by such funds. All amounts credited to the trust fund shall be available for expenditure by the secretary to be used for medical assistance payments to entities authorized by the general court, and for which a public entity has contractually agreed to direct funds to the trust fund. Any amount in excess of such medical assistance payments may be credited to the General Fund and the amount of all such expenditures shall be subject to annual approval by the general court. The maximum payments from the account shall not exceed those permissible for federal reimbursement under Title XIX or Title XXI of the Social Security Act or any successor federal law. The comptroller may

make payments, including payments during the accounts payable period, in anticipation of revenues, including receivables due and collectibles during the months of July and August, and shall establish procedures for reconciling overpayments or underpayments from the account. Such procedures shall include, but not be limited to, appropriate mechanisms for refunding public funds directed to the trust fund and federal reimbursements upon recoupment of any such overpayments. The executive office of health and human services shall submit to the secretary of administration and finance and the house and senate committees on ways and means a schedule of such payments 10 days before any expenditures, and no funds shall be expended without an enforceable agreement with or legal obligation imposed upon a public entity to make an intergovernmental transfer in an appropriate amount to the trust fund.

Section 2RRR. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Department of Mental Retardation Trust fund, administered by the secretary of health and human services. There shall be credited to the fund (a) any receipts from the assessment collected pursuant to section 27 of chapter 118G, including transfers by the department of mental retardation of amounts sufficient to pay the assessment for public facilities, (b) any federal financial participation received by the commonwealth as a result of expenditures funded by such assessments, and (c) any interest thereon. The secretary may authorize expenditures of amounts from such account without further appropriation. The comptroller shall transfer to the fund no later than the first

business day of each quarter, the amounts indicated by the department of mental retardation to provide the appropriate payment adjustments for operating the intermediate care facilities for the mentally retarded and the community residences serving individuals with mental retardation. The comptroller shall establish such procedures as may be necessary to accomplish the purpose of this section, including procedures for the proper transfer, accounting, and expenditures of funds under this section. The comptroller may make payments in anticipation of receipts and shall establish procedures for reconciling overpayments and underpayments from said trust fund. The secretary shall account for revenue and expenditure activity within said trust fund.

Section 2SSS. There shall be established on the books of the Commonwealth a separate fund administered by the secretary for administration and finance to be known as the Safety Net Transitional Assistance Trust Fund. The purpose of the funds shall be to assist acute hospitals and community health centers. Said amounts shall be used solely for the administration of the provisions of section 57 of chapter 7. Amounts credited to the fund shall be held as an expendable trust and shall not be subject to further appropriation.

SECTION 4. Section 1 of chapter 32 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting in line 191, after the word "Authority", the following:-

, Commonwealth Care Health Insurance Exchange Corporation

SECTION 5. Section 4 of chapter 32A of the General Laws, as appearing in the 2004 Official Edition is hereby amended by striking in line 22, the following "The group" and is hereby further amended by striking lines 23 through 33,inclusive.

SECTION 6. Chapter 32B of the General Laws, is hereby amended by adding the following:-

Section 3B. (a) Upon acceptance of this section as hereinafter provided, a governmental unit shall establish and maintain a committee, known as the group insurance committee. Said committee will be comprised of 7 members as follows: 4 persons to be appointed by the appropriate public authority, 2 persons to be elected by organizations of the governmental unit's employees, and 1 person who shall be a retiree of the governmental unit and who shall be appointed to membership on such committee by the appropriate public authority. Four members of the committee shall constitute a quorum. The committee may act upon a majority vote of a quorum at any meeting held in conformity with section 23B of chapter 39.

(b) The group insurance committee shall have plenary authority to require changes in the design of any and all group general or blanket hospital, surgical, medical, dental and other health insurance plans, including the services of a health care organization, and including coverage offered on a self-funded basis pursuant to sections 3A, 11 or 12; provided however that this authority shall not include adjustments to the municipality and employee premium contributions. The plan

design changes that may be required may include, but not be limited to, changes to co-pay amounts and deductibles. Such changes as the group insurance committee requires shall be (1) effective as the date of the termination or modification of an existing contract, (2) not subject to any amendments by the appropriate public authority and (3) shall not be subject to collective bargaining pursuant to Chapter 150E.

(c) This section shall take effect in a county, city, town or district upon its acceptance in the following manner: in a county, by a vote of the county commissioners; in a city having a Plan D or a Plan E charter, by a majority vote of its city council and approved by the manager; in any other city by majority vote of its city council and approved by the mayor; in a town, by vote of the town meeting or town council; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting.

SECTION 7. Section 1 of chapter 62D of the General Laws, as appearing in the 2004 Official Edition is hereby amended by striking in lines 27-33, the words ", or an amount owed to the division of health are finance and policy on behalf of the uncompensated care pool by a person or guarantor of a person who received free care services paid for in whole or in part by the uncompensated care pool, pursuant to subsection (m) of section 18 of chapter 118G"

SECTION 8. Said section 1 of chapter 62D, as so appearing, in further amended by striking in lines 49, the words, "owing the Uncompensated Care Trust Fund ad-" and is further

amended by striking lines 50-53, inclusive and replacing with the following, "who does not comply with section 2 of chapter 111A.

SECTION 9. Section 8 of chapter 62D, as appearing in the 2004 Official Edition is hereby amended by striking lines 14-16, inclusive and replacing it with the following:-

> With respect to set-off proceeds collected in accordance with subsection (d) of section 2 of chapter 111A the department of revenue shall deposit such proceeds in the Medical Escrow Account Fund established pursuant to section *2000* of chapter 29.

SECTION 10. Section 13 of chapter 62D, as appearing in the 2004 Official Edition is hereby amended by striking lines 6-13, inclusive and replacing it with the following:-

> assistance under Title XIX of the Social Security Act; (iv) the department of revenue for obligations to the Medical Escrow Account Fund established pursuant to section *2000* of chapter 29; (v) unpaid division of employment and training liabilities; (vi) the board of higher education; (vii) other debts as defined in section 1 in the order certified by the comptroller; (viii) the department of transitional assistance; (ix) any overdue debt certified by the

SECTION 11. Section 3 of chapter 62E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking in lines 7-9, inclusive the following:-

> with respect to payments for free care services made from the uncompensated care pool pursuant to section 18 of chapter 118G

and replacing it with the following:-

, and the Commonwealth Care Health Insurance Exchange with respect to eligibility in the Safety Net Care Health Insurance Program, pursuant to chapter 176R

SECTION 12. Said section 3 of chapter 62E, as so appearing, is further amended by adding in line 13, after the word "commonwealth." the following:-

The commissioner shall also develop and implement a system for the purpose of verifying compliance with section 2 of chapter 111A.

SECTION 13. Section 51 of chapter 111 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking in lines 27-28, "Uncompensated Care Trust Fund pursuant to section 18 of chapter 118G, " and replaced with the following:-

Safety Net Care Expendable Trust Fund established in section 2PPP of chapter 29.

SECTION 14. The General Laws are hereby amended by inserting the following:-

CHAPTER 111A

INDIVIDUAL HEALTH COVERAGE

Section 1. As used in this chapter the following words shall unless the context clearly requires otherwise have the following meanings:--

"Creditable coverage," coverage of an individual under any of the following health plans with no lapse of coverage for more than 63 days:

(a) a group health plan;

(b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(e) 10 U.S.C. chapter 55;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under 5 U.S.C. chapter 89;

(i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191;

(j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); or

(k) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996 as it is amended, or by regulations promulgated under that act.

"Health care coverage", coverage under any of the following health plans described herein that does not have an annual hospital deductible that is greater than what is defined in section 223 of the Internal Revenue Code for contributions to Health Savings Accounts and has an annual hospital benefit that is at least equal to or more than $100,000:

(a) a group health plan;

(b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(e) 10 U.S.C. chapter 55;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under 5 U.S.C. chapter 89;

(i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191;

(j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); or

(k) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996 as it is amended, or by regulations promulgated under that act.

Section 2. (a) As of January 1, 2007, the following individuals over the age of 18 shall obtain and maintain health care coverage or shall offer proof of financial security: (1) residents of the commonwealth, (2) individuals who become residents of the commonwealth within 63 days, in the aggregate, and (3) individuals who within 63 days have terminated any prior creditable coverage.

(b) For purposes of this section a person shall be deemed a resident of the commonwealth if he:

(1) obtained an exemption pursuant to clause Seventeenth, Seventeenth C, Seventeenth C 1/2, Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first A, Forty-first B, Forty- first C, Forty-second or Forty-third of section 5 of chapter 59;

(2) obtained an exemption pursuant to section 5C of said chapter 59;

(3) filed a Massachusetts resident income tax return pursuant to chapter 62;

(4) obtained a rental deduction pursuant to subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;

(5) declared in a home mortgage settlement document that the mortgaged property located in the commonwealth would be occupied as his principal residence;

(6) obtained homeowner's liability insurance coverage on property that was declared to be occupied as a principal residence;

(7) filed a certificate of residency and identified his place of residence in a city or town in the commonwealth in order to comply with a residency ordinance as a prerequisite for employment with a governmental entity;

(8) paid on his own behalf or on behalf of a child or dependent for whom the person has custody, resident in-state tuition rates to attend a state-sponsored college, community college or university;

(9) applied for and received public assistance from the commonwealth for himself or his child or dependent of whom he has custody;

(10) has a child or dependent of whom he has custody who is enrolled in a public school in a city or town in the commonwealth, unless the cost of such education is paid for by him, such child or dependent, or by another education jurisdiction;

(11) is registered to vote in the commonwealth;

(12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or

(13) is a resident under any other written criteria under which the commissioner of revenue may determine residency in the commonwealth.

(c) To satisfy the proof of financial security and to pay for certain medical expenditures pursuant to subsection (a) of section 2, an individual shall present to the Exchange, a bond in the amount of $10,000 or shall deposit with the Exchange, $10,000 in an account that shall bear interest.

(d) Every person who files an individual return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person, as of the last day of the taxable year for which the return is filed, had health care coverage in force or financial security in place as required under paragraph (a) of this section. If the person does not so indicate, or indicates that he neither had such coverage in force nor had such security in place, then the tax shall be computed on the return without benefit of the personal exemption set forth in paragraph (B)(b) of section 3 of chapter 62, or, in the case of a person who files jointly with a spouse, without benefit of one-half of the personal exemption set forth in such paragraph. If the person indicates that he had such coverage in force or such security in place but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall compute the tax for the taxable year without benefit of the personal exemption set forth in paragraph (B)(b) of section 3 of chapter 62, or, in the case of a person who files jointly with a spouse, without benefit of one-half of the personal exemption set forth in such paragraph, first giving notice to such person of his intent to do so and an opportunity for a hearing, in accordance with rules prescribed by the commissioner.

(e) If in any taxable year a taxpayer does not comply with the requirement of paragraph (a) of this section, the commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments described in paragraph (f) of this section; provided, however, that the amount retained shall not exceed $10,000 or $20,000 in the case of a joint return filed by spouses neither of whom complied with

such requirement, and provided further that nothing in this paragraph shall be considered to authorize the commissioner to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies as debts described in subsections (i) through (vii) of section 13 of chapter 62D.

(f) The monies held by the commonwealth in sections (c) and (e) shall be used only to pay for medical claims for healthcare services provided by a hospital to the individual during the period when the individual was not in compliance with section 2.

(g) If an individual has complied with section 2 for over 6 months or is no longer claiming residency in the commonwealth, the individual within 3 years of the last deposit into the fund on the individual's account shall provide documentation in a form prescribed by the commissioner of revenue so that any and all monies accrued in the individual's account may be remitted back to the individual. If after 3 years the individual has not made such a request, any monies in the individual's account shall revert to the state pursuant to chapter 200A.

Section 3. Any judgment payable by an individual to a hospital for charges incurred during a period when the individual failed to comply with section 2 shall include an order permitting the attachment of the wages of the individual to satisfy such judgment.

Section 4. The commissioner of revenue in consultation with the Commonwealth Care Health Insurance Exchange board shall promulgate such rules and regulations, as necessary, to carry out the purposes of this chapter.

SECTION 15. Section 1 of chapter 111K of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking in lines 7-8, the words " including the uncompensated care pool established by section 18 of chapter 11G,"

SECTION 16. Section 23 of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking in lines 55, the following number "(1)" and is further amended by striking in lines 57-59 the following:-

, (2) persons for whom hospitals and community health centers claim payments from the uncompensated care pool under chapter 118G;

SECTION 17. Section 1 of chapter 118G of the General Laws, as appearing in the 2004 Official Edition is hereby amended by striking lines 12 through 20, inclusive, lines 186 through 199, inclusive, lines 211 through 213, inclusive, and lines 274 through 281, inclusive.

SECTION 18. Said section 1 of chapter 118G , as so appearing, is hereby amended by inserting after the definition of "Child" the following:-

"Clinician", any of the following health care professionals licensed pursuant to chapter 112: a physician, a podiatrist, a physical therapist, an occupational therapist, a dentist, an optometrist, a nurse, a nurse practitioner, a chiropractor, a psychologist, an

independent clinical social worker, a speech-language pathologist, an audiologist, a marriage and family therapist, and a mental health counselor.

SECTION 19. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Comprehensive Cancer Center" the following :-

"Cost Information", data including costs, charges, and payment for services.

SECTION 20. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Enrollee" the following:-

"Exchange", the Commonwealth Care Health Insurance Exchange established pursuant to chapter 176Q.

SECTION 21. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Executive Office" the following :-

"Facility", a hospital, clinic, pharmacy, ambulatory surgery center, community health center, nursing facility licensed pursuant to chapter 111 or a home health agency.

SECTION 22. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Gross Patient Service Revenue" the following :-

"Health Care Provider", a clinician, a facility, or a physician group.

SECTION 23. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Hospital Service Plan" the following :-

"Insurer", a carrier authorized to transact accident and health insurance pursuant to chapter 175, a non-profit hospital service corporation licensed pursuant to chapter 176A, a non-profit medical service corporation licensed pursuant to chapter 176B, a dental service corporation licensed pursuant to chapter 176E, an optometric service corporation organized pursuant to chapter 176F and a health maintenance organization licensed pursuant to chapter 176G.

SECTION 24. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Patient" the following:-

"Payment", the allowed amount of a health care claim and shall include both the amount paid by the insurer and the amount required to be paid by the insured under the terms of the health insurance plan.

SECTION 25. Said section 1 of chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Pediatric Specialty Unit" the following:-

"Physician Group Practice", two or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.

SECTION 26. Section 2 of chapter 118G, as appearing in the 2004 Official Edition, is hereby amended by adding at the end of line 19 the word "and" and is further amended by striking lines 20-21, and is further amended by striking in line 22, "(d)" and replacing it with "(b)"

SECTION 27. Section 3 of chapter 118G, as appearing in the 2004 Official Edition, is hereby amended by striking in line 36, the words "Uncompensated Care Trust Fund" and replacing it with the words "Safety Net Care Expendable Trust Fund"

SECTION 28. Said chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting the following:-

Section 6B. (a) The division shall collect data that can be used to develop health care quality and cost data for the consumer health information internet site established by the Exchange pursuant to section 16 of chapter 176Q. The division, in consultation with the Exchange, shall determine the information required to enable consumers to make informed decisions about their medical care. The division shall specify by regulation the data that must be submitted by health care providers, pharmacies, payors, and insurers to the Exchange internet site including, but not limited to, payment and claims data by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, surgical procedures, diagnostic tests, therapeutic procedures, emergency department visits, hospital ambulatory and outpatient visits, and other health services as determined by the division. Cost information shall include, but not be limited to, the average non-governmental payment for each service or category of service received by each facility, clinician, or physician practice on behalf of insured patients. The division may collect payment and claims information from insurers if it determines that this information is necessary to meet the goals and deadlines under section 16 of chapter 176Q. Information provided by insurers shall not be a public record and shall be

exempted from disclosure under chapter 66. The division shall aggregate payment information for all insurers, and the division shall not publicly release or disclose the payment rates of any individual insurer.

(b) The division shall analyze the data collected and provide its analysis to the Exchange for publication on the internet site. The division may contract with an independent organization to; (i) identify and, as necessary, develop appropriate measures of cost and quality for inclusion on the website, (ii) collect and analyze data related to cost and quality, and (iii) present data for the website in a format understandable to the average consumer. To the extent possible, the division, the Exchange, and any independent contractor shall collaborate with other entities that develop, collect and publicly report cost and quality measures, and shall work with these entities to develop and maintain a master provider directory to facilitate the linkage of multiple data sources with information related to the same provider.

(c) Any health care provider or insurer that fails, without just cause, to submit required data to the division on a timely basis may be subject to a penalty of $1,000 per day for each day's delay. The maximum penalty under this section shall be $50,000 per licensed professional or facility or insurer per year.

SECTION 29. Section 18 of chapter 118G is hereby repealed.

SECTION 30. Section 18A of chapter 118G is hereby repealed.

SECTION 31. Section 27 of chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking in line 27, the words "Uncompensated Care Trust Fund" and replacing it with the words "Department of Mental Retardation Trust Fund"—

SECTION 32. Section 6 of chapter 150E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by adding in line 10, the following:-

For purposes of this section, the terms and conditions of employment shall not include the design of any and all group general or blanket hospital, surgical, medical, dental and other health insurance plans, including the services of a health care organization, and including coverage offered on a self-funded basis pursuant to sections 3A, 11 or 12 of chapter 32B

SECTION 33. Section 110 of chapter 175 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by adding the following:-

(O) An insurer authorized to issue or deliver within the commonwealth any general or blanket policy of insurance under the provisions of this section may only contract to sell any general or blanket policy of insurance with an employer if said insurance is offered by that employer to all full-time employees, who live in the commonwealth, and provided further; the employer must offer the same health insurance premium contribution dollar amount for each specific or general blanket policy of insurance for all employees.

SECTION 34. Chapter 176A of the General Laws is hereby amended by adding the following:-

Section 8 1/2. A corporation organized under this chapter may only contract to sell a group non-profit hospital service contract to an employer if the group non-profit hospital service contract is offered by that employer to all full-time employees, who live in the commonwealth, and provided further; the employer must offer the same health insurance premium contribution dollar amount for each specific group non-profit hospital service contract for all employees.

SECTION 35. Chapter 176B of the General Laws, is hereby amended by the adding the following:-

Section 3B. A medical service corporation organized under this chapter may only enter into a group medical service agreement with an employer if the group medical service agreement is offered by that employer to all full-time employees, who live in the commonwealth, and provided further; the employer must offer the same health insurance premium contribution dollar amount for each specific group medical service agreement for all employees.

SECTION 36. Chapter 176G of the General Laws, is hereby amended by adding the following:-

Section 7A. A health maintenance organization may only enter into a group health maintenance contract with an employer if the group health maintenance contract is offered by that employer to all full-time employees, who live in the commonwealth,

and provided further; the employer must offer the same health insurance premium contribution dollar amount for each specific group health maintenance contract for all employees.

Section 16A. The commissioner shall not disapprove a health maintenance contract on the basis that it includes a deductible that is consistent with the requirements for a high deductible health plan as defined in section 223 of the Internal Revenue Code and implementing regulations or guidelines.

SECTION 37. The Title of Chapter 176J of the General Laws, as appearing in the 2004 Official Edition, shall be amended to add after the word "group" the following:-

AND INDIVIDUAL

SECTION 38. Section 1 of chapter 176J of the General Laws, as appearing in the 2004 Official Edition, shall be amended by striking in line 10, "case characteristics" and replacing it with "rate basis type".

SECTION 39. Said section 1 of chapter 176J, as so appearing, shall be further amended by inserting after the definition of "Adjusted average market premium price" the following:-

"Base premium rate", the midpoint rate within a modified community rate band for each rate basis type of each health benefit plan of a carrier.

SECTION 40. Said section 1 of chapter 176J, as so appearing, shall be further amended by striking lines 12-13 and replacing it with the following:-

"Benefit level", the health benefits, including the benefit payment structure of or service delivery and network of, provided by a health benefit plan.

SECTION 41. Said section 1 of chapter 176J, as so appearing, is further amended by striking lines 14-23 and replacing it with the following:-

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G.

SECTION 42. Said section 1 of chapter 176J, as so appearing, is further amended by striking lines 24-25 in its entirety.

SECTION 43. Section 1 of chapter 176J, as so appearing, is further amended by inserting after the definition of "Commissioner" the following:-

"Commonwealth Care Seal of Approval", the corporation's approval that a health benefit plan which it offers meets certain standards regarding value.

"Corporation", the Commonwealth Care Insurance Exchange Corporation, as established in chapter 176Q.

"Creditable coverage", coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days:

(a) a group health plan;

(b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(e) 10 U.S.C. chapter 55;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under 5 U.S.C. chapter 89;

(i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191;

(j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); or

(k) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996 as it is amended, or by regulations promulgated under that act.

SECTION 44. Said section 1 of chapter 176J, as so appearing, is further amended by striking in line 38 the word "person" and replacing it with the words "employee or eligible individual"

SECTION 45. Said section 1 of chapter 176J, as so appearing, is further amended by inserting after the definition "Eligible dependent" the following:-

"Eligible individual", an individual who is a resident of the commonwealth.

SECTION 46. Said section 1 of chapter 176J, as so appearing, is further amended by striking in lines 48, 49 and 50 "companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one business" and replacing it with the following:-

a business shall be considered to be one eligible small business or group if (1) it is eligible to file a combined tax return for purpose of state taxation or (2) its companies are affiliated companies through the same corporate parent.

SECTION 47. Said section 1 of chapter 176J, as so appearing, is further amended by adding in line 54 after the word "definition" the following:-

An eligible small business that exists within a MEWA shall be subject to this chapter.

SECTION 48. Said section 1 of chapter 176J, as appearing, is further amended by striking lines 55-60, inclusive and replacing it with the following:-

"Emergency services", services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

SECTION 49. Said section 1 of chapter 176J, as so appearing, is further amended by adding in line 70, after the word "employee" the letter "s" and is further amended by adding in line 71, after the letters "dents" the following "or eligible individuals and their dependents"

SECTION 50. Said section 1 of chapter 176J, as so appearing, is further amended by adding in line 76 after the word "rate," the words "tobacco usage"

SECTION 51. Said section 1 of chapter 176J, as so appearing, is further amended by inserting after the definition of "Group base premium rates" the following:-

"Group health plan", an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002, to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of this chapter, medical care means amounts paid for (i) the diagnosis, cure,

mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (ii) amounts paid for transportation primarily for and essential to medical care referred to in clause (i); and (iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii). Additionally any plan, fund or program which would not be, but for section 2721(e) of the Federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that such plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to clause (a), as an employee welfare benefit plan which is a group health plan; (a) in the case of a group health plan, the term "employer" also includes the partnership in relation to any partner; and (b) in the case of a group health plan, the term "participant" also includes:

(1) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(2) in connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual; if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

SECTION 52. Said section 1 of chapter 176J, as so appearing, shall be amended by striking lines 82 through 102, inclusive and replacing it with the following:-

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C.

55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 53. Said section 1 of chapter 176J, as so appearing, is hereby further amended by striking in line 103 the following ", trade association".

SECTION 54. Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting after the definition "Mandated benefit" the following:-

"Member", any and all persons enrolled in a health benefit plan.

"Modified community rate", a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a health benefit plan is the same without regard to health status; provided, however, that premiums may vary due to factors such as age, group size, industry,participation rate, geographic area, wellness program usage, tobacco usage, or benefit level for each rate basis type as permitted by this chapter.

SECTION 55. Said section 1 of chapter 176J, as so appearing, is further amended by striking lines 130-160, inclusive and replacing it with the following:-

"Participation rate", the percentage of eligible employees or eligible individuals electing to participate in a health benefit plan out of all eligible employees or eligible individuals, or the percentage of the sum of eligible employees and eligible dependents electing to participate in a health benefit plan out of the sum of all eligible employees and eligible individuals and their eligible dependents at the election of the carrier. In either case, the numbers used to compute these percentages shall not include any eligible employee or eligible dependent who does not participate in an eligible small business' or eligible individual's health benefit plan, but who is enrolled in a health benefit plan through a source other than the eligible small business or eligible individual.

"Participation requirement", a policy provision, or a carrier's underwriting guideline if there is no such provision, which requires that an eligible group or eligible individual attain a certain participation rate in order for a carrier to accept the group for enrollment in the plan. For eligible individuals or eligible groups of 5 or fewer eligible persons, a carrier may require a participation rate not to exceed 100 percent. For groups of 6 or more eligible persons, a carrier may require a participation rate not to exceed 75 percent.

"Preexisting conditions provision", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Genetic

information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information.

SECTION 56. Said section 1 of chapter 176J, as so appearing, is further amended by inserting after the definition "Rate basis type" the following:-

"Rating factor", characteristics including, but not limited to age, industry, rate basis type, geography, wellness program usage or tobacco usage.

SECTION 57. Said section 1 of chapter 176J, as so appearing, is further amended by inserting after the definition "Rating period" the following:-

"Resident'", a natural person living in the commonwealth; provided, however, that the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify such person as a resident.

"Trade Act/HCTC-Eligible Persons", any eligible Trade Adjustment Assistance recipient as defined in 35(c)(2) of section 201 of Title II of Public Law 107-210, eligible alternative Trade Adjustment Assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient that is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, pursuant to Public Law 107-210.

SECTION 58. Said section 1 of chapter 176J, as so appearing, is further amended by a adding in line 192 after the word "expenses" the following:-

, but in all cases pays for emergency services

SECTION 59. Section 2 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by adding at the end of line 3, "and all health benefit plans issued, made effective, delivered or renewed to any eligible individual on or after January 1, 2006," and is further amended by adding in line 4, after the word "carrier" the following " or the Corporation", and is further amended by striking in line 5 the word "which" and replacing it with the word "that"

SECTION 60. Section 3 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by striking it in its entirety and replacing it with the following:-

Section 3. (a) Premiums charged to every eligible small business for a health benefit plan issued or renewed on or after April 1, 1992, or eligible individuals for a health benefit plan issued or renewed on or after January 1, 2006, shall satisfy the following requirements:

(1) For every health benefit plan issued or renewed to eligible small groups on or after April 1, 1992 and to eligible individuals on or after January 1, 2006, including a certificate issued to an eligible small group or eligible individual that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, a carrier shall develop a group base premium rate for a class of business. The group base premium rates charged by a carrier to each eligible group or eligible individual during a rating period shall not exceed 2 times the group

base premium rate which could be charged by that carrier to the eligible group or eligible individual with the lowest group base premium rate for that rate basis type within that class of business in that group's or individual's geographic area. In calculating the premium to be charged to each eligible small group or eligible individual, a carrier shall develop a group base premium rate for each rate basis type and may develop and use any of the rate adjustment factors identified in paragraphs (2) through (7), inclusive of this subsection, provided that after multiplying any of the used rate adjustment factors by the group base premium, the resulting product for all adjusted group base premium rate combinations fall within rate bands ranging between sixty-six one-hundredths and one and thirty-two one-hundredths that is required of all products offered to eligible small groups and eligible individuals. In addition, carriers may apply additional factors, identified in subsection (b) that would apply outside the sixty-six one-hundredths to one and thirty-two one-hundredths rate band. All other rating adjustments are prohibited. Carriers may offer any rate basis types, but rate basis types that are offered to any eligible small employer or eligible individual shall be offered to every eligible small employer or eligible individual for all coverage issued or renewed on and after January 1, 2006.

(2) A carrier may establish an age rate adjustment that applies to both eligible individuals and eligible small groups, the value of which may not extend beyond the range of sixty-six one-hundredths to one and thirty-two one-hundredths.

(3) A carrier may establish an industry rate adjustment that applies only to eligible small groups, the value of which may not extend beyond the range of sixty-six one-hundredths to one and thirty-two one-hundredths. If a carrier chooses to establish industry rate adjustments, every eligible small group in an industry shall be subject to the applicable industry rate adjustment.

(4) A carrier may establish participation-rate rate adjustments that apply only to eligible small groups for any health benefit plan or plans for any ranges of participation rates below the minimum participation requirements established in accordance with the definition of participation requirement in section one, the value of which shall be expressed as a number. The participation-rate rate adjustments must be based upon actuarially sound analysis of the differences in the experience of groups with different participation rates. If a carrier chooses to establish participation-rate rate adjustments, every eligible small group with a participation rate within the ranges defined by the carrier shall be subject to the applicable participation-rate rate adjustment.

(5) A carrier may apply a wellness program rate discount that applies to both eligible individuals and eligible small groups who follow those wellness programs that have been approved by the commissioner. The value of the wellness program rate discount shall be up to 5 percent. If a carrier establishes a wellness program rate discount every eligible insured following

the wellness program shall be subject to the applicable wellness program rate discount.

(6) A carrier may apply a tobacco use rate discount that applies to both eligible small groups and eligible individuals who can certify, in a method approved by the commissioner, that eligible individuals and their eligible dependents or eligible small group employees and their eligible dependents have not used tobacco products within the past year.

(b) (1) A carrier may establish a benefit level rate adjustment for all eligible individuals and eligible small groups that shall be expressed as a number. The number shall represent the relative actuarial value of the benefit level, including the health care delivery network, of the health benefit plan issued to that eligible small group or eligible individual as compared to the actuarial value of other health benefit plans within that class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible small group and every eligible individual shall be subject to the applicable benefit level rate adjustment.

(2) The commissioner shall establish not less than 5 distinct regions of the state for the purposes of area rate adjustments. A carrier may establish an area rate adjustment for each distinct region, the value of which shall range from eight-tenths to one and one-fifth. If a carrier chooses to establish area rate adjustments, every eligible small group and every eligible individual within each area shall be subject to the applicable area rate adjustment.

(3) A carrier shall establish a rate basis type adjustment factor for eligible individuals which shall be expressed as a number. The number shall represent the relative actuarial value of the rate basis type, which shall include at least the following 4 categories: single, two adults, one adult and children, and family.

(4) A carrier may establish a group size rate adjustment that apply to both eligible individuals and eligible small groups, the value of which shall range from ninety-five one-hundredths to one and ten one-hundredths. If a carrier chooses to establish group size rate adjustments, every eligible individual and eligible small group shall be subject to the applicable group size rate adjustment.

(c) (1) A carrier that, as of the close of the calendar year 2004 had a combined total of 5,000 or more eligible employees and eligible dependents as defined by chapter 176J and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under chapter 176G, shall be required by January 1, 2006 to file a plan with the Corporation, for its consideration, which could attain the Commonwealth Care Seal of Approval.

(2) As of January 1, 2007, a carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to

qualified small businesses or eligible individuals pursuant to its license under chapter 176G, shall be required annually to file a plan with the Corporation for its consideration, which could attain the Commonwealth Care Seal of Approval; provided however the plan shall be filed no later than October 1 of any calendar year.

(d) (1) A carrier that, as of the close of the calendar year 2004 had a combined total of 5,000 or more eligible employees and eligible dependents as defined by chapter 176J and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its authority under chapter 175, chapter 176A or chapter 176B shall be required by January 1, 2006 to file a plan with the Corporation for its consideration, which could attain the Commonwealth Care Seal of Approval.

(2) As of January 1, 2007, a carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the Corporation for its consideration, which could attain the Commonwealth Care Seal of Approval; provided however the plan shall be filed no later than October 1 of any calendar year.

(e) For the purposes of this section, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under chapter 175, 176A or 176B if said health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

SECTION 61. Section 4 of chapter 176J, as appearing in the 2004 Official Edition, shall be amended by striking lines 2 through 107 inclusive and replaced with the following:-

individual and every small business, including a certificate issued to an eligible small group or eligible individual that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, as well as to their eligible dependents, every health benefit plan that it provides to any other eligible individual or eligible small business. No health plan may be offered to an eligible individual or an eligible small business unless it complies with the requirements of this chapter. Upon the request of an eligible small business or an eligible individual, a carrier must provide that group or individual with a price for every health benefit plan that it provides to any eligible small business or eligible individual. Except under the conditions set forth in paragraph (3) of subsection (a) and paragraph (2) of subsection (b), every carrier shall accept for enrollment any eligible small business or eligible individual which seeks to enroll in a health benefit plan. Every carrier shall permit every eligible small business group to enroll all eligible persons and all eligible dependents; provided that the commissioner shall

promulgate regulations which limit the circumstances under which coverage must be made available to an eligible employee who seeks to enroll in a health benefit plan significantly later than he was initially eligible to enroll in a group plan.

(2) A carrier shall enroll any person who meets the requirements of an eligible individual into a health plan if such person requests coverage within 63 days of termination of any prior creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to reasonable verification of eligibility.

(3) A carrier shall enroll any eligible individual who does not meet the requirements of subsection (2) into a health benefit plan; provided, however, that a carrier may impose a pre-existing condition exclusion for no more than 6 months or a waiting period, which shall be applied uniformly without regard to any health status-related factors, for no more than 2 months following the individual's effective date of coverage. If a policy includes a waiting period, emergency services shall be covered. In determining whether a pre-existing condition exclusion or a waiting period applies, all health plans shall credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage and if the previous coverage was reasonably actuarially equivalent to the new coverage. Coverage shall become effective within 30 days of the date of application. The commissioner shall promulgate regulations relative to pre-existing condition exclusions and waiting periods permissible pursuant to this section.

(4) No policy may provide for any waiting period if the eligible individual has not had any creditable coverage for the 18 months prior to the effective date of coverage.

(b) (1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. The commissioner is authorized to promulgate regulations, which ensure that a carrier cannot use the provisions of this paragraph to circumvent the intent of this chapter.

(2) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual or eligible small business has repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual or eligible small business has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or (c) the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person

was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the individual or small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan.

(3) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that: (a) the small business fails at the time of issuance or renewal to meet a participation requirement established in accordance with the definition of participation rate in section one; or, (b) acceptance of an application or applications would create for the carrier a condition of financial impairment, and the carrier makes such a demonstration to the same commissioner.

(c) (1) Every health benefit plan shall be renewable as required by the Health Insurance Portability and Accountability Act of 1996 as amended, or by regulations promulgated under that act.

(2) A carrier shall not be required to renew the health benefit plan of an eligible individual or eligible small business if the individual or small business: (a) has not paid the required premiums; or, (b) has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group; or, (c) failed to comply in a

material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; or, (d) fails, at the time of renewal, to meet the participation requirements of the plan; or, (e) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (f) in the case of a group, is not actively engaged in business.

(3) A carrier may refuse to renew enrollment for an eligible individual, eligible employee or eligible dependent if: (a) the eligible individual, eligible employee or eligible dependent has committed fraud, misrepresented whether or not he or she is an eligible individual, eligible employee or eligible dependent, or misrepresented information necessary to determine his eligibility for a health benefit plan or for specific health benefits; or, (b) the eligible individual, eligible employee or eligible dependent fails to comply in a material manner with health benefit plan provisions.

(d) Nothing in this chapter shall be construed to prohibit a carrier from offering coverage in a group to a person, and his dependents, who does not satisfy the hours per week or period employed portions of the definition of eligible employee.

SECTION 62. Section 5 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by adding in line 1 after the word "eligible" the following "individual, eligible" and is further amended by striking lines 8 through 12, inclusive and replacing it with the following:-

months following an eligible individual's, eligible employee's or eligible dependent's effective date of coverage and may only relate to a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Pre-existing condition may not apply to a pregnancy existing on the effective date of coverage. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may not impose a pre-existing condition exclusion or waiting period for more than 3 months following the individual's effective date of coverage.

SECTION 63. Said section 5 of chapter 176J, as so appearing, is further amended by striking line 14 in its entirety and replacing it with "eligible individual, eligible employee, eligible dependent, all health benefit plans shall credit the" and is further amended by striking in line 15 the words, "was covered" and replacing it with the words "with creditable coverage" and striking in line 17 the word, "thirty" and replacing it with the number "63"

SECTION 64. Said section 5 of chapter 176J, as so appearing, is further amended by striking in line 21, the word "six" and replacing it with the number "2" and is further amended by striking line 23, in its entirety and replacing it with the following:-

"plan; provided that an eligible individual who has not had creditable coverage for the 18 months prior to the effective date of coverage shall not be subject to a waiting period; provided further, however that a carrier may not impose any waiting pe-"

SECTION 65. Said section 5 of chapter 176J, as so appearing, is further amended by adding in line 24, after the word "had" the word "creditable" and is further amended by striking line 28, in its entirety and replacing it with the following:-

waiting period applies to an eligible individual, eligible employee, or eligible dependent all health

SECTION 66. Said section 5 of chapter 176J, as so appearing, is further amended by striking lines 36 through 39, inclusive.

SECTION 67. Section 6 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by adding in line 3 after the word "eligible" the words "individuals or eligible" and is hereby further amended by adding after the word "benefit" the words "or include networks that differ from those of a health plan's overall network. Any plans receiving the Commonwealth Care Seal of Approval are not required to include coverage of mandated benefits pursuant to section 6 of chapter 176Q."

SECTION 68. Section 7 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by striking lines 4 through 10, inclusive and is further amended by striking out in line 11 the letter "(b)" and replacing it with the letter "(a)" and is further amended by striking out in line 14 the letter "(c)" and replacing it with the letter "(b)".

SECTION 69. Said section 7 of chapter 176J, as so appearing, is further amended by striking lines 16 through 21, inclusive and striking in line 22 the words "health benefit plan offered by the carrier" and replace it with the following:-

(c) Every carrier, as a condition of doing business under the jurisdiction of this chapter on and after January 1, 2006, shall electronically file with the commissioner an annual actuarial opinion that the carrier's rating methodologies and rates to be applied in the upcoming calendar year comply with the requirements of this chapter and any regulations promulgated under the authority of this chapter. In addition, every carrier shall file electronically an annual statement of the number of eligible employees and eligible dependents, as of the close of the preceding calendar year, enrolled in a health benefit plan offered by the carrier. A carrier that may require eligible individuals or eligible small groups with 5 or fewer eligible employees to obtain coverage through an intermediary or the Corporation shall file a list of those intermediaries, with associated contact information, prior to requiring those small groups to go through an intermediary to obtain small group health coverage.

SECTION 70. Said section 7 of chapter 176J, as so appearing, is further amended by adding after line 29 the following:-

(d) Every carrier shall notify the commissioner regarding any material changes or additions to the actuarial methodology at least 30 days prior to the effective date of the change or addition, including amendments to rate basis types, rating factors, intermediary relationships, distribution networks and products offered within this market.

SECTION 71. Section 8 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by adding in line 2 after the word "Employer" the words "and Individual" and is further amended by striking line 4 and replacing it with the following:-

on or after April 1, 1992 and all carriers issuing health benefit plans to an eligible small business or eligible individuals on or after January 1, 2006, shall be mem-

SECTION 72. Said section 8 of chapter 176J, as so appearing, is further amended by striking in line 5 the words " Non-profit hospital and medical ser-" and is further amended by striking lines 6 and 7 in its entirety.

SECTION 73. Said section 8 of chapter 176J, as so appearing, is further amended by striking in line 10 the words "small business"

SECTION 74. Said section 8 of chapter 176J, as so appearing, is further amended by adding in line 41 after the word "writing" the words "individual or eligible" and is further amended by striking line 47 and replacing it with the following:-

gible group, individual or any dependent of such an employee or individual with the

SECTION 75. Said section 8 of chapter 176J, as so appearing, is further amended by adding in line 51, after the word "businesses" the words "or eligible individuals"

SECTION 76. Said section 8 of chapter 176J, as so appearing, is further amended by adding in line 81, after the word "issuance" the words " for eligible individual and eligible small groups" and is further amended by adding in line 84 after the word "group" the words "or eligible individual"

SECTION 77. Said section 8 of chapter 176J, as so appearing, is further amended by striking in lines 98 and 99 the words "covering eligible small businesses"

SECTION 78. Section 9 of chapter 176J, as so appearing in the 2004 Official Edition is hereby amended by adding in line 186 after the words " an eligible" the following " individual or eligible"

SECTION 79. Section 1 of chapter 176M of the General Laws, as appearing in the 2004 Official Edition is hereby amended by inserting after the definition of "Carrier" the following:-

"Closed guaranteed issue health plan", a nongroup health plan issued by a carrier to an individual, as well as any covered dependents, after November 1, 1997 but before January 1, 2006. A carrier may permit an individual to continue to add new dependents to a policy issued under a closed guaranteed issue health plan.

SECTION 80. Said section 1 of chapter 176M, as so appearing, is further amended by inserting after the definition of "Subscriber" the following:-

"Trade Act/HCTC-Eligible Persons", any eligible Trade Adjustment Assistance recipient as defined in 35(c)(2) of section 201 of Title II of Public Law 107-210, eligible alternative Trade Adjustment Assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient that is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, pursuant to Public Law 107-210.

SECTION 81. Section 3 of chapter 176M, as appearing in the 2004 Official Edition is hereby amended by adding in line 8 after the word "section" the words "through December 31, 2005"

SECTION 82. Said section 3 of chapter 176M, as so appearing, is further amended by adding in line 48 after the word "application" the following:-

With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may not impose a pre-existing condition exclusion or waiting period for more than 3 months following the individual's effective date of coverage.

SECTION 83. Said section 3 of chapter 176M, as so appearing, is further amended by striking lines 55 through 80, inclusive and replacing it with the following:-

(d) As of January 1, 2006, a carrier may no longer offer, sell or deliver a health plan to any person to whom it does not have such an obligation pursuant to an individual policy, contract or agreement with an employer or through a trust or association; provided however, that a closed guaranteed issue plan or a closed health plan shall be subject to all the other requirements of this chapter. A carrier shall be obligated to renew a closed guarantee issue health plan, and a closed plan. A carrier may discontinue a closed guarantee issue health plan or a closed plan when the number of subscribers in a closed guaranteed issue plan or a closed plan is not more than 25 per cent of the plan's December 31, 2004 subscriber total. A closed guaranteed issue health plan and a closed plan's 2004 enrollment figure shall be determined by the commissioner based on enrollment figures submitted to the division of insurance as of

December 31, 2004. The commissioner shall approve or disapprove of a carrier's request to discontinue a closed guaranteed issue health plan or a closed plan based on the most recent figure submitted to the division of insurance and a review of the policy's termination provisions. A carrier shall file its rates for a closed guaranteed health plan and a closed plan in accordance with subsection (a) of section 5. A closed guaranteed health plan and a closed plan shall not otherwise be subject to the requirements of said sections 4 and 5. No carrier shall add any new rating factor to the rating methodology which was applicable to its closed plan as of August 15, 1996. Nothing in this section shall prohibit a subscriber from enrolling in a health plan if the subscriber meets the requirements of this chapter.

(e) No carrier shall knowingly issue a health benefit plan to any individual other than an eligible individual. A carrier may renew a nongroup health plan previously issued to an individual who is not an eligible individual only if said individual either was insured under said plan as of August 15, 1996 or was insured as of August 15, 1996 under a nongroup health plan issued by said carrier and said plan is no longer offered by the carrier.

SECTION 84. Section 1 of chapter 176N of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by striking lines 4 through 39, inclusive and replacing it with the following:-

"Emergency services", services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a

prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

"Health Plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are

payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 85. Section 2 of chapter 176N ,as so appearing, is hereby amended by striking in lines 12 and 13 the words "or (2) a pregnancy existing on the effective date of coverage" and is further amended by striking in line 16 the word "thirty" and replacing it with the number "63"

SECTION 86. Said section 2 of chapter 176N, as so appearing, is further amended by striking in line 21 the word "six" and replacing it with the number "2" and is further amended by adding in line 22 after the word" plan" the following:-

;provided that an eligible individual who has not had creditable coverage for the 18 months prior to the effective date of coverage shall not be subject to a waiting period

SECTION 87. The General Laws are hereby amended by inserting the following:-

CHAPTER 176Q

COMMONWEALTH CARE HEALTH INSURANCE EXCHANGE

Section 1. It is declared that for the benefit of the people of the commonwealth, the increase of their commerce, welfare and prosperity and the improvement of their health and living conditions, it is essential that this and future generations of citizens be given the fullest opportunity to have and retain health care insurance at an affordable price. It is declared further that the people of the commonwealth have a direct interest in all of its citizens purchasing health insurance to encourage personal responsibility, ensure a healthy workforce, sustain a vibrant health care delivery system and develop a fairer allocation of health care costs. It is recognized that costs associated with health insurance are increasingly burdensome and that it is essential that citizens be provided with quality health insurance products at a lower cost, which are easily understandable and convenient to purchase. It is also recognized that these conditions do not exist today in the commonwealth. Accordingly, it is the purpose of this chapter and the policy of the commonwealth to provide a means to encourage the development of innovative and affordable health insurance products and encourage the purchase of those products.

Section 2. As used in this chapter the following words shall unless the context clearly requires otherwise have the following meanings: -

"Board", board of the Commonwealth Care Health Insurance Exchange.

"Business entity", a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G.

"Commissioner", the commissioner of the division of insurance.

"Commonwealth Care Seal of Approval", board approval that the health benefit plan meets certain standards regarding value.

"Corporation", the Commonwealth Care Health Insurance Exchange.

"Division", the Division of Health Care Finance and Policy.

"Eligible individuals", an individual who is a resident of the commonwealth; provided that the individual is not offered subsidized health insurance by an employer with more than 50 employees.

"Eligible small groups," groups, any sole proprietorship, labor union, educational, professional, civic, trade, church, not-for-profit or social organization or firms, corporations, partnerships or associations actively engaged in business that on at least 50 percent of its working days during the preceding year employed at least one but not more than 50 employees.

"Exchange", Commonwealth Care Health Insurance Exchange.

"Health benefit plans," any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of

chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Mandated benefits", a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan.

"Participating institution", eligible groups that purchase health benefit plans through the Exchange.

"Premium assistance payments", payments made to carriers by the Exchange.

"Safety Net Care Health Insurance Program enrollees", individuals and their dependents eligible to enroll in the Safety Net Care Health Insurance Program.

"Safety Net Care Health Insurance Program", program administered pursuant to chapter 176R.

Section 3. (a). There is hereby created a body politic and corporate and a public instrumentality to be known as the Commonwealth Care Health Insurance Exchange Corporation, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board,

bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the Corporation of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the Corporation is to implement the Commonwealth Care Health Insurance Exchange, whose purpose is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups as described in this chapter.

(b) The Corporation shall consist of a 9 member board. The secretary of health and human services, the secretary for administration and finance, the executive director of the group insurance commission, the secretary of economic development, and 5 additional members appointed by the governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one shall be an employee health benefits plan specialist, one shall be an attorney specializing in employee benefit plans, one shall be a member of a labor union, and one shall represent the interests of small businesses. No appointee may be an employee of any licensed carrier authorized to do business in the commonwealth. Upon the initial appointments, the governor shall designate two non-ex officio members for a term of 3 years; 2 non-ex officio members for a term of 4 years; and one non-ex officio member for a term of 5 years. Thereafter, all appointments shall serve a term of 5 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The governor shall appoint the chairperson and the board shall annually elect 1 of its members to

serve as vice-chairperson. Each member of the board serving ex officio may appoint a designee pursuant to section 6A of chapter 30.

(c) Five members of the board shall constitute a quorum, and the affirmative vote of 5 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the Corporation. Members shall serve without pay, but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court no less than annually.

(d) Any action of the Corporation may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the Corporation shall be subject to section 11A 1/2 of chapter 30A; but, said section 11A 1/2 shall not apply to any meeting of members of the Corporation serving ex officio in the exercise of their duties as officers of the commonwealth so long as no matters relating to the official business of the Corporation are discussed and decided at the meeting. The Corporation shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the Corporation shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the Corporation shall be considered to be public funds for purposes of chapter 12A. The operations of the Corporation shall be subject to chapter 268A and chapter 268B.

(e) The board shall appoint an executive director, who shall supervise the administrative affairs and general management and operations of the Corporation and

who shall also serve as secretary of the Corporation, ex officio. The executive director shall receive a salary commensurate with the duties of the office, and may be removed by the board for cause. The executive director may appoint other officers and employees of the Corporation necessary to the functioning of the Corporation. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the Corporation. The executive director shall, with the approval of the board: (i) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board; (ii) employ professional and clerical staff as necessary; (iii) report to the board on all operations under his control and supervision; (iv) prepare an annual budget and manage the administrative expenses of the Corporation; and (v) undertake any other activities necessary to implement the powers and duties set forth in this chapter.

(f) Within 120 days of the effective date of this act, the executive director shall submit a plan of operation to the board and any recommended amendments to this chapter or other general laws to assure the fair, reasonable and equitable administration of the Exchange that is consistent with the provisions of this chapter and any other applicable laws and regulations, which shall provide for the effective operation of the Exchange.

(g) As of July 1, 2006, the Corporation shall commence offering health benefit plans pursuant to section 6 of this chapter.

Section 4. The purpose of the Corporation shall be to implement the Commonwealth Care Health Insurance Exchange. The goal of the Exchange is to facilitate the purchase of health care insurance products through the Exchange at an affordable price by eligible individuals, groups and safety net insurance plan enrollees. For these purposes the Corporation is authorized and empowered:

(a) To develop a plan of operation for the Exchange, this shall include, but not be limited, to the following:

(1) establish procedures for operations of the Corporation;

(2) establish procedures for selecting an executive director;

(3) establish procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the Exchange;

(4) establish procedures for the enrollment of eligible individuals, groups and Safety Net Care Health Insurance program enrollees;

(5) establish a plan for operating a health insurance service center to provide eligible individuals, groups and safety net insurance program enrollees, with information on the Exchange and manage Exchange enrollment;

(6) establish and manage a system of collecting all premium payments made by, or on behalf of individuals obtaining health insurance coverage

through the Exchange, including any premium payments made by enrollees, employees, unions or other organizations;

(7) establish and manage a system of remitting premium assistance payments to the carriers;

(8) establish a plan for publicizing the existence of the Exchange and the Exchange's eligibility requirements and enrollment procedures;

(9) develop criteria for determining that certain health benefit plans shall no longer be made available through the Exchange, and to develop a plan to decertify and remove the seal of approval from certain health benefit plans; and

(10) develop a standard application form for eligible individuals, groups seeking to purchase health insurance through the Exchange, and safety net insurance program enrollees, seeking a premium assistance payment which shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history and payment method.

(b) To determine each applicant's eligibility for purchasing insurance offered by the Exchange, including eligibility for premium assistance payments.

(c) To seek and receive any grant funding from the Federal government, departments or agencies of the commonwealth, and private foundations.

(d) To contract with professional service firms as may be necessary in its judgment, and to fix their compensation.

(e) To contract with companies which provide third-party administrative and billing services for insurance products.

(f) To charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter.

(g) To adopt by-laws for the regulation of its affairs and the conduct of its business.

(h) To adopt an official seal and alter the same at pleasure.

(i) To maintain an office at such place or places in the commonwealth as it may designate.

(j) To sue and be sued in its own name, plead and be impleaded.

(k) To establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extend otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974.

(l) To approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations.

(m) To create and deliver to the department of revenue a form that the department distribute to every person to whom it distributes information regarding personal income tax liability, including, without limitation, every person who filed a personal income tax return in the most recent calendar year that informs the recipient of the requirements to establish and maintain health care coverage.

(n) To create for publication by the 31st of each May, the Safety Net Care Insurance Program consumer price schedule.

(o) To maintain membership lists from carriers in an electronic form that will provide such lists on a monthly basis.

(p) To create a premium assistance reinsurance reserve fund as deemed necessary by the board.

Section 5. (a) The Corporation may only offer health benefit plans to eligible individuals, and groups as defined in this chapter.

(b) An eligible individual or small group's participation in the Exchange shall cease if coverage is cancelled pursuant to section 4 of chapter 176J.

Section 6. (a) Only health insurance plans that have been authorized by the commissioner and underwritten by a carrier may be offered through the Exchange.

(b) Each health plan offered through the Exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.

(c) No health plan shall be offered through the Exchange that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

(d) The Corporation may only make available health benefit plans as defined in chapter 176J, which include the following categories of coverage:

(1) Preventive and primary care;

(2) Emergency services;

(3) Surgical benefits;

(4) Hospitalization benefits;

(5) Ambulatory patient benefits; and

(6) Mental health benefits.

(e) Plans receiving the Commonwealth Care Seal of Approval shall not be required to include benefits pursuant to section 47H of chapter 175; section 8k of chapter 176A; section 4J of chapter 176B; and the sixth sentence of section 4 of chapter 176G or any other mandated benefits, as the board determines, and shall not be required to meet any other benefit limitations or health care delivery network design in any other law; provided that the carrier must offer a health benefit plan that includes a prescription drug benefit option. Any health benefit plan receiving the

Commonwealth Care Seal of Approval may exclude through December 31, 2008 any new mandated benefit coverage implemented after January 1, 2006.

Section 7. Eligible small groups seeking to be a participating institution shall, as a condition of participation in the Exchange, enter in a binding agreement with the Exchange which, at a minimum, shall stipulate the following:

(a) that the employer agrees that, for the term of agreement, the employer will not offer to eligible individuals to participate in the Exchange any separate or competing group health plan offering the same, or substantially the same, benefits provided through the Exchange;

(b) that the employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the Exchange and the amounts of the employer contributions, if any, to the such health plan, provided that, for the term of the agreement with the Exchange, the employer agrees not to change or amend any such criteria or contribution amounts at anytime other than during a period designated by the Exchange for participating employer health plans;

(c) that the employers will participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 U.S.C. sections 104, 105, 106 and 125; and

(d) that the employer agrees to make available, in a timely manner, for review by the executive director, any of the employer's documents, records or information that the Exchange reasonably determines is necessary for the executive director to:

(1) verify that the employer is in compliance with applicable Federal and commonwealth laws relating to group health insurance plans, particularly those provisions of such laws relating to non-discrimination in coverage; and

(2) verify the eligibility, under the terms of the health plan, of those individuals enrolled in the employer's participating health plan.

Section 8. (a) The Exchange shall administer the Safety Net Care Health Insurance Program as described in chapter 176R and remit premium assistance payments beginning on July 1, 2006 to those carriers providing health plans to Safety Net Care enrollees.

(b) The Exchange after an affirmative vote by the board shall from time to time requisition funds from the Safety Net Care Expendable Trust Fund established in section 2PPP of chapter 29 by notifying the secretary for administration and finance, in a form prescribed by the secretary, such amounts as the Exchange deems necessary to meet the current and future obligations and expenses of the Safety Net Care Health Insurance Program; provided future obligations do not exceed 30 days.

Section 9. (a) The Exchange shall enter into interagency agreements with the department of revenue to verify income data for participants in the Safety Net Care Health Insurance Program. Such written agreements shall include provisions permitting the Exchange to provide a list of individuals participating in or applying for the Safety Net Care Health Insurance Program, including any applicable members of the households of such individuals, which would be counted in determining eligibility, and to furnish relevant information including, but not limited to, name, social security number, if available, and other data required to assure positive identification. Such written agreements shall include provisions permitting the department of revenue to examine the data available under the wage reporting system established under section 3 of chapter 62E. The department of revenue is hereby authorized to furnish the Exchange with information on the cases of persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources.

Section 10. The commonwealth, through the group insurance commission shall enter into an agreement with the Exchange whereby employees and contractors of the commonwealth who are ineligible for group insurance commission enrollment may elect to purchase a health benefit plan through the Exchange. The group insurance commission will develop a protocol for making pro-rated contributions to the chosen plan on behalf of the commonwealth.

Section 11. The Commonwealth Care Seal of Approval shall be assigned to health benefit plans that the board determines (1) meets the requirements of section 6(d); (2) provides good value to consumer; and (3) is offered through the Exchange.

Section 12. (a) When an eligible individual or group is enrolled in the Exchange by a producer licensed in the commonwealth, the health plan chosen by each eligible individual or group shall pay the producer a commission that shall be determined by the board.

(b) Any labor union, educational, professional, civic, trade, church, not-for-profit or social organization may enroll its individual eligible members, or the individual members of its member organizations, in health benefit plans offered through the Exchange, and shall receive a payment amount determined by the board from each health plan for persons who are enrolled unless the payment is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

(c) Notwithstanding any general law to the contrary, membership organizations that enroll eligible individuals or groups in health benefit plans offered through the Exchange do not have to be licensed as an insurance producer unless such an arrangement is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

Section 13. (a) The Exchange shall be authorized to apply a surcharge to all health benefit plans and shall be used only to pay for administrative and operational

expenses of the Exchange; provided that such a surcharge shall be applied uniformly to all health benefit plans offered through the Exchange. These surcharges shall not be used to pay any premium assistance payments pursuant to the Safety Net Care Insurance Program as described in chapter 176R.

(b) Each carrier participating in the Exchange shall be required to furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his or her duties under this chapter.

(c) The board may withdraw a health plan from the Exchange only after notice to the carrier.

Section 14. (a) All expenses incurred in carrying out the provisions of this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the Corporation hereunder beyond the extent to which monies shall have been provided under the provisions of this chapter.

(b) The Corporation shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer, or employee of the Corporation acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the Corporation shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

(c) No person shall be liable to the commonwealth, to the Corporation or to any other person as a result of his activities, whether ministerial or discretionary, as a member, officer or employee of the Corporation except for willful dishonesty or intentional violation of the law; provided, however, that such person shall provide reasonable cooperation to the Corporation in the defense of any claim. Failure of such person to provide reasonable cooperation shall cause him to be jointly liable with the Corporation, to the extent that such failure prejudiced the defense of the action.

(d) The Corporation may indemnify or reimburse any person, or his personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the Corporation; provided that the defense of settlement thereof shall have been made by counsel approved by the Corporation. The Corporation may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action hereunder shall be brought more than three years after the date upon which the cause thereof accrued.

(f) Upon dissolution, liquidation or other termination of the Corporation, all rights and properties of the Corporation shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the Corporation, beyond that necessary for retirement of any

indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 15. The Corporation shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its members, to the governor and to the state auditor, such reports to be in a form prescribed by the members, with the written approval of said auditor. The members or said auditor may investigate the affairs of the Corporation, may severally examine the properties and records of the Corporation, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the Corporation. The Corporation shall be subject to biennial audit by the state auditor.

Section 16. (a) The Exchange shall establish and maintain a consumer health information Internet site which shall be accessible on the web by January 1, 2006. The website shall contain information comparing the cost and quality of health care services. The website may also contain general information related to health care as the Exchange determines to be appropriate. The website shall be designed to enable consumers to make informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format understandable to the average consumer. The Exchange shall take appropriate action to publicize the availability of its Internet site.

(b) By January 1, 2007, the Internet site shall, at a minimum, include comparative cost and quality information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, surgical procedures, diagnostic tests, therapeutic procedures, emergency department visits, hospital ambulatory and outpatient visits, and other health services as determined by the division in consultation with the Exchange. Cost information shall include the average payment for each service or category of service received by each facility, clinician, or physician practice on behalf of insured patients. Cost and payment information shall be aggregated for all insurers, and the Exchange shall not publicly release or disclose the payment rates of any individual insurer.

(c) The Internet site shall be updated on an annual basis and additional comprehensive cost and quality information shall be posted as it becomes available. The Internet site shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which valid and reliable data exist, (ii) general information related to each service or category of services for which comparative information is provided, (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and patient satisfaction and (iv) comparative price information regarding the average reimbursement the provider receives for the service. Whenever possible, price and quality information shall be presented together.

(d) The Exchange may contract with an independent organization to provide technical assistance, including, but not limited to, development and maintenance of

the Internet site. The independent organization, if hired, would work with the division and the Exchange to review and make recommendations regarding measures that are already available in the public domain and otherwise in use and consider whether it is cost effective to license commercially available data and consumer decision support tools. If the parties all agree that making available through the Internet site only those measures already available in the public domain would not fully comply with the requirements of paragraph (c) of this section, the independent organization shall assist in the development of recommendations for measures for inclusion on the Internet site and shall notify the division of health care finance and policy of the data required to be collected in order to construct those measures. The independent organization shall recommend comparative information to be included on the Internet site whether it is more practical and useful to consumers to: (i) list such service separately or as part of a group of related services and (ii) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

Section 17. No later than 3 years after the Exchange begins operation and every year thereafter, the Corporation shall conduct a study of the Exchange and the persons enrolled in the Exchange and shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on status and activities of the Corporation based on data collected in the study. The report shall also be available to the general public upon request. The study shall review:

(1) the operation and administration of the Exchange, including surveys and reports of health benefits plans available to eligible individuals and on the experience of the plans. The experience on the plans shall include data on enrollees in the Exchange and enrollees purchasing health benefit plans as defined by chapter 176J outside of the Exchange, the operation and administration of the safety net care health insurance program described in chapter 176R, expenses, claims statistics, complaints data, how the Exchange met its goals, and other information deemed pertinent by the Corporation; and

(2) any significant observations regarding utilization and adoption of the Exchange

Section 18. The Exchange will conduct an annual survey of health insurance survey of commonwealth residents. The survey shall include data relating to age, income, occupation, type of insurance, employer size, employer contribution to health insurance, and other data that may be necessary to demonstrate the health insurance status of the commonwealth's residents.

Section 19. The Exchange may promulgate such rules and regulations as necessary to implement the intent of this chapter.

Section 20. The chapter, being necessary for the welfare of the commonwealth and its inhabitants, shall be liberally construed to affect the purposes hereof.

SECTION 88. The General Laws are hereby amended by inserting the following:-

CHAPTER 176R

SAFETY NET CARE HEALTH INSURANCE PROGRAM

Section 1. It is declared that the commonwealth wishes for all of its residents to have access to affordable private health insurance products for the betterment of their physical and mental well-being and the protection of their financial security. Notwithstanding the efforts of the government, employers and individuals, certain people are unable to afford basic health insurance protection. It is in the interest of the commonwealth to assist these individuals as the state's economy, public health, healthcare system and insurers are significantly improved by a healthier populace. To date, the commonwealth's assistance to these individuals has resulted in limited improvements to their health and has caused financial distress for certain healthcare providers. Accordingly, it is the purpose of this chapter and the policy of the commonwealth to provide premium assistance for the purchase of private health insurance products to those individuals not eligible for existing governmental programs and unable to afford private health insurance; provided that the safety net care program is subject to the availability of federal financial participation.

Section 2. As used in this chapter the following words shall unless the context clearly requires otherwise have the following meanings:--

"Acute hospital", the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under section 51 of chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric, and maternity

beds, as defined by the department of public health.

"Ambulatory surgical center", any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Centers for Medicare and Medicaid Services for participation in the Medicare program.

"Ambulatory surgical center services", services described for purposes of the Medicare program pursuant to 42 USC § 1395k(a)(2)(F)(I). These services include facility services only and do not include surgical procedures.

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G.

"Commissioner", commissioner of insurance.

"Division", Division of Healthcare, Finance and Policy.

"Exchange", Commonwealth Care Health Insurance Exchange as defined in chapter 176Q.

"Health benefit plan" , any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under

chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of

said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Hospital", any hospital licensed under section 51 of chapter 111, the teaching hospital of the University of Massachusetts Medical School and any psychiatric facility licensed under section 19 of chapter 19.

"Medicaid" the medical assistance program administered pursuant to chapter 118 E and in accordance with Title XIX of the Federal Social Security Act or any successor statute.

"Medicare", the medical insurance program established by Title XVIII of the Social Security Act.

"Office", office of Medicaid within the Executive Office of Health and Human Services.

"Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health services and ambulatory surgical centers for ambulatory surgical center services on or after the effective date of this chapter; provided, however, that "payments subject to surcharge" shall not include (i) payments, settlements, and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies, (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries,

or persons enrolled in policies issued pursuant to chapter 176K or similar policies issued on a group basis; and provided further, that "payments subject to surcharge" may exclude amounts established in regulations promulgated by the exchange for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

"Premium assistance payments", payments made to carriers by the Exchange.

"Private sector charges", gross patient service revenue attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other publicly aided patients, free care and bad debt.

"Safety Net Care Expendable Trust Fund", "fund", established pursuant to section 2PPP of chapter 29.

"Safety Net Care Health Insurance Program enrollees", individuals and their dependents eligible to enroll in the Safety Net Care Health Insurance program.

"Safety Net Care Health Insurance Program", "program", established under this chapter.

"Surcharge payor," an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals; provided, however, that the terms

surcharge payor shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients, and the workers compensation program established pursuant to chapter 152.

Section 3. The Exchange may remit premium assistance payments to carriers beginning July 1, 2006 on behalf of Safety Net Care Health Insurance program enrollees. In order to determine the amount of an individual's premium assistance payments, the Exchange shall establish a schedule setting forth the amounts of the premium assistance payments calculated pursuant to regulations established by the Exchange. This schedule shall be published annually on or before May 31, 2006.

Section 4. The Exchange shall determine the eligibility of an individual to participate in the program. An individual shall be eligible to participate in the program if, an individual's annual gross household income does not exceed 300% of the federal poverty level; provided further, the individual has been a resident of the commonwealth for the previous 12 months; provided that the individual is a citizen or resident of the United States; provided further, that the individual is not eligible for any Federal means-tested public benefit pursuant to section 431of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; and provided further that

(1) the individual is not eligible for Medicare pursuant to 42 U.S.C. 1395 et seq;

(2) the individual is not eligible for the child health insurance program pursuant to section 16c of chapter 118E;

(3) the individual is not eligible for any program administered under chapter 118E;

(4) the individual is not a full time or part-time student required to participate in qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state;

(5) the individual's employer does not contribute at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan;

(6) the individual who would be eligible for coverage under a plan offered by their spouse's or parent's employer but the employer does not contribute at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan and

(7) the individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan.

Section 5. The Exchange may waive the provisions of section 4 (a) (5) and (6), provided that the individual's employer is in compliance with section 110 of chapter 175, section 8 ½ of chapter 176A, section 3B of chapter 176B or section 7A of chapter 176G, provided further, that the employer's health insurance premium

contribution for the applying individual, which shall be the median health insurance premium contribution made by the employer to all of its full-time employees participating in the employer sponsored health plan, must be paid to the Exchange. The Exchange must use the employer's health insurance premium contribution for the individual to first offset the commonwealth's premium assistance for individual with any residual amount offsetting the individual's payment.

Section 6. Premium assistance payments made pursuant to chapter 176R, shall only be available to individuals that purchase health benefit plans with no annual deductible and have the Commonwealth Care Seal of Approval as described in section 11 of chapter 176Q.

Section 7. (a) Before March 1st of each year, the division in consultation with the Exchange, shall establish each acute hospital's liability to the fund using the best data available, as determined by the division. The division shall update each acute hospital's liability to the fund as updated information becomes available. The division shall specify an appropriate mechanism for interim determination and payment of an acute hospital's liability to said fund. In the case of a transfer of ownership, an acute hospital's liability to the fund shall be assumed by the successor in interest.

(b) The division shall establish an appropriate mechanism for enforcing an acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled payment to said fund. Such enforcement mechanism may include notification to the office requiring an offset of payments on the Title XIX claims of

any such hospital, any health care provider under common ownership with the hospital or any successor in interest to the hospital, from the office in the amount of payment owed to said fund including any interest and late fees, and to transfer the withheld funds into said fund. If the office offsets claims payments as ordered by the division, the office shall be deemed not to be in breach of contract or any other obligation for payment of services, and providers to which payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the office, or, in the case of a hospital that contracts with the office for emergency services only, in accordance with its obligation for providing services to Title XIX recipients pursuant to chapter 118G. In no event shall the division direct the office to offset claims unless a hospital has maintained an outstanding obligation to the fund for a period longer than 45 days and has received proper notice that said division intends to initiate enforcement actions in accordance with the authority of the division.

(c) Acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge. The surcharge shall be distinct from any other amount paid by a surcharge payor for the services of a hospital or ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge percentage and (ii) amounts paid for said services by a surcharge payor. Before each succeeding March 1, the division in consultation with the Exchange shall determine the surcharge percentage incorporating any adjustments from prior years. In each determination or redetermination of the surcharge percentage, the division shall use the best data

available as determined by the division. The division shall incorporate all adjustments prospectively, rather than retrospective payments or assessments.

(d) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an amount equal to the surcharge described in subsection (a) as a separate and identifiable amount distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical center services. Each surcharge payor shall pay such surcharge amount to the division for deposit in the Safety Net Care Expendable Trust Fund on behalf of said acute hospital or ambulatory surgical center. Upon the written request of a surcharge payor, the division may implement another billing or collection method for such surcharge payor; provided, however, that the division has received all information that it requests which is necessary to implement such billing or collection method; and provided further, that the division shall specify by regulation the criteria for reviewing and approving such requests and the elements of such alternative method or methods.

(e) The division shall specify appropriate mechanisms that provide for determination and payment of a surcharge payor's liability, including requirements for data to be submitted by surcharge payors, acute hospitals and ambulatory surgical centers. A surcharge payor's liability to the fund shall in the case of a transfer of ownership be assumed by the successor in interest to the surcharge payor.

(f) The division shall establish an appropriate mechanism for enforcing a surcharge payor's liability to said fund in the event that a surcharge payor does not make a scheduled payment to said fund; provided, however, that the Exchange may, for the purpose of administrative simplicity, establish threshold liability amounts

below which enforcement may be modified or waived. Such enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to exceed the annual prime rate and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement mechanism may also include notification to the office requiring an offset of payments on the claims of the surcharge payor, any entity under common ownership or any successor in interest to the surcharge payor, from the office in the amount of payment owed to said fund including any interest and penalties, and to transfer the withheld funds into said fund. If the office offsets claims payments as ordered by the division, said office shall be deemed not to be in breach of contract or any other obligation for payment of noncontracted services, and a surcharge payor to which payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the office. In no event shall the division direct the office to offset claims unless the surcharge payor has maintained an outstanding liability to the fund for a period longer than 45 days and has received proper notice that said division intends to initiate enforcement actions in accordance with the regulations of the division.

(g) Any surcharge payor that fails to file any data, statistics or schedules or other information required under this section or by any regulation promulgated by the division or which falsifies the same, shall be subject to a civil penalty of not more than $5,000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall bring any appropriate action,

including injunctive relief, as may be necessary for the enforcement of the provisions of this section.

Section 8. All expenses incurred in carrying out the program shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the Exchange hereunder beyond the extent to which monies shall have been provided under the provisions of this chapter.

Section 9. The Exchange shall promulgate rules and regulations as necessary to carry out the provisions of this chapter.

Section 10: The chapter, being necessary for the welfare of the commonwealth and its inhabitants, shall be liberally construed to affect the purposes hereof.

SECTION 89. Notwithstanding any general or special law to the contrary, 30 days after the effective date of this act, the state comptroller shall transfer $10,000,000 from the Stabilization Fund to the Commonwealth Care Health Insurance Exchange Corporation established under chapter 176Q for the purposes of educating and increasing the awareness of uninsured residents of the commonwealth as to their options for becoming insured through the Corporation.

SECTION 90. Notwithstanding any general or special law to the contrary, 30 days after the effective date of this act, the state comptroller shall transfer $7,000,000 from the Stabilization Fund to the Commonwealth Care Health Insurance Exchange Corporation established under chapter 176Q for administrative and operating expenses of the Corporation.

SECTION 91. The Essential Community Provider Expendable Trust Fund as established by section 133 of chapter 140 of the acts of 2003 and as amended by chapter 40 of the acts of 2004 is hereby repealed. Within 30 days of the effective date of this section, all remaining monies shall be transferred by the state comptroller to the Safety Net Care Expendable Trust Fund established in section 2PPP of chapter 29.

SECTION 92. The Distressed Provider Expendable Trust Fund, as established by chapter 241 of the acts of 2004, is hereby repealed. Within 30 days of the effective date of this section, all remaining monies shall be transferred by the comptroller to the Safety Net Care Expendable Trust Fund established in section 2PPP of chapter 29.

SECTION 93. Notwithstanding any general or special law to the contrary, from July 1, 2006 through June 30, 2008, only carriers that are Medicaid managed care organizations contracted with the commonwealth as of July 1, 2006 to provide Medicaid managed care services may receive from the Commonwealth Care Health Insurance Exchange established pursuant to chapter 176Q, premium assistance payments pursuant to the Safety Net Care Health Insurance Program established in chapter 176R; provided however that if the Medicaid managed care organizations as of January 30, 2007 do not have a combined total of 100,0000 safety net care enrollees as defined in section 1 of chapter 176R, in health benefit plans receiving premium assistance payments; or as of December 31, 2007 do not have a combined total of 120,000 safety net care enrollees in health benefit plans receiving premium assistance payments; or as of March 31, 2007 do not have a combined total of

142,500 safety net care enrollees in health benefit plans receiving premium assistance payments, non-Medicaid managed care organizations may receive premium assistance payments.

SECTION 94. Notwithstanding any general or special law to the contrary, for hospital fiscal year 2007, pursuant to section 5(a) of chapter 176R, a hospital's liability to the Safety Net Care Expendable Trust Fund established in section 2PPP of Chapter 29 shall equal the product of (1) the ratio of its private sector charges to all hospitals' private sector charges; and (2) $160,000,000.

SECTION 95. Notwithstanding any general or special law to the contrary. for hospital fiscal year 2007 pursuant to section 5(c) of chapter 176R, the division of health care finance and policy, shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to surcharge .The division of health care policy and finance in consultation with the Commonwealth Care Health Insurance Exchange established in chapter 176Q, shall determine the surcharge percentage before the effective date of this section and may re-determine the surcharge percentage if the division projects that the initial surcharge will produce less than $140,000,000 or more than $160,000,000.

SECTION 96. Sections 29, 30, 91 and 92 shall take effect June 30, 2006.

SECTION 97. Section 14 shall be effective for taxable years beginning on or after January 1, 2007.

SECTION 98. Unless otherwise specified, this act shall take effect immediately.